DOCUMENT RESUME

ED 350 728 EC 301 522

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TITLE Inter-Agency Collaboration between a Clinical Early Intervention Program and a Residential Care Setting To Meet the Needs of a Toddler.
PUB DATE Dec 91
NOTE 17p.; Paper presented at the National Center for Clinical Infant Programs Training Institute (7th, Washington, DC, December 6-8, 1991).
PUB TYPE Speeches/Conference Papers (150) -- Reports - Descriptive (141)

EDRS PRICE MF01/PC01 Plus Postage.
DESCRIPTORS Acquired Immune Deficiency Syndrome; *Agency Cooperation; At Risk Persons; Attachment Behavior; *Behavior Problems; *Child Caregivers; *Communication Disorders; *Early Intervention; Group Homes; Parent Child Relationship; Preschool Education; Residential Programs; *Staff Role; Toddlers

ABSTRACT

This paper discusses the interagency collaboration between a clinical assessment and intervention program for toddlers offered through the psychiatry department of a large metropolitan west coast medical center and a group home for infants and young children who are positive for the human immunodeficiency virus (HIV). The paper presents the case of a developmentally at-risk 2-year-old whose mother and twin brother were HIV-positive. The healthy toddler resided in the group home with his sick twin and was cared for by staff there, and the staff social worker contacted the early intervention program for assistance with the boy's behavior and communication skills. Agency staff in the group home for HIV-positive children took on the role of surrogate parents. One caregiver attended early intervention group sessions and another caregiver participated in home visits. The paper points out problems in working effectively with multiple caregivers having different levels of knowledge about developmental issues and varying degrees of tolerance for the boy's negativistic behavior. The main treatment goal was to help the boy's caregivers appreciate his need for a significant attachment relationship with them. Intervention areas also focused on helping his caregivers to actively prepare him for change, facilitate his transitions, and acknowledge his emotional experiences. (JDD)

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ED350728

National Center for Clinical Infant Programs

Seventh Biennial National Training Institute

Washington, D.C.

December 6-8, 1991

Inter-Agency Collaboration Between a Clinical Early Intervention Program and a Residential Care Setting to Meet the Needs of a Toddler

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Inter-Agency Collaboration Between a Clinical Early Intervention Program and a Residential Care Setting to Meet the Needs of a Toddler

Abstract

This paper discusses the interagency collaboration between a short-term assessment and clinical intervention program for toddlers offered through the department of psychiatry in a large metropolitan West Coast Medical Center and a group home for HIV positive infants and young children. The child to be presented is a developmentally at-risk two and a half year-old whose twin is HIV positive. Details of the modification of a primarily parent-child oriented program to accommodate this child's circumstances of multiple caregivers in a group home setting will be provided. The challenge of providing appropriate clinical intervention to meet the complex and unique needs of both the child and the group home will be discussed. Evaluation and critiques of the inter-agency collaboration will be presented.

Introduction

The following is a challenging and dramatic case involving a developmentally at-risk toddler whose mother and twin brother is HIV-positive. One of the challenging aspects of this case was the inter-agency collaboration between the staff of our Brief Evaluation and Intervention Group (BEIG) and the staff of Caring for Babies with Aids (CBA), a group home for HIV-positive infants and young children. The Brief Evaluation and Intervention Group is a short-term assessment and clinical intervention program that is the most recent addition to the services of The Early Childhood Center under the direction of Saul L. Brown, M.D., Chairman of the Department of Psychiatry at Cedars-Sinai Medical Center in Los Angeles, California. The program is designed to serve families with children between the ages of two and four who commonly present with difficulties such as developmental delays, impulsivity, language delays, power struggles, difficulty relating, and separation anxiety. The clinical focus is primarily on the child's social and emotional development and family relationships. Intervention commonly involves attempting to understand and alter dysfunctional patterns of relating which may be perpetuating a child's behavioral problems. This is a group treatment approach consisting of four families per group. The groups are led by experienced child development specialists who assess the parent/child interaction, provide developmental guidance and formulate and implement clinical interventions. Graduate level child development interns extend the intervention in weekly home

visits. This provides the opportunity for further observation, discussion and guidance within the context of the family's home environment. Other components of the program include an observed family interview, a developmental assessment, and a summary family meeting for the purpose of providing feedback and planning future interventions if needed.

The group component of the program is designed to provide a predictable and consistent experience for the children. Simple routines, a carefully structured environment and repetitive activities provide our staff with opportunities to observe parent/child interactions. We assess a child's ability to participate in a structured group as well as to cope with transitions and separation. Each of the bi-weekly groups consists of routine play group activities such as a snack time, outside time, and a good-bye singing ritual. During the children's outside time, parents remain indoors for a discussion facilitated by the child development specialist. This time away from the parents allows us to observe the child functioning autonomously and socializing with other children. While the children are outside with the child development interns, the parents feel free to discuss their current concerns and feelings, share behavioral strategies and evaluate what seems to be working and what remains problematic. Continuous observations and interventions along with on-going staff collaboration and the use of video-taping result in a clinical formulation. Based on this formulation interventions are discussed and planned with the family.

Eddie and His Family

To protect the confidentiality of the family and caregivers, names and some details have been changed. Caring for Babies with Aids is a group home providing a nurturing environment for HIV-positive infants and young children. Their staff consists of a director, a social worker, and caregivers who care for five to six infants/children at any one time. The staff social worker from the group home contacted the Early Childhood Center requesting assistance with Eddie who is a two and a half year-old boy whose mother and twin brother are HIV-positive. Eddie's mother is a young Caucasian woman in her early twenties, who prior to her present occupation as a

waitress had worked as a prostitute. She reported that she continued to engage in high-risk sexual behavior throughout her pregnancy. The twins' father is a non-English speaking immigrant in his late twenties who works as a tow truck driver.

The mother reported a full-term pregnancy, however, she was unaware that she was carrying twins until the day before delivery. She characterized the boys as "calm babies." When the boys were two months old their parents separated and their father moved in with a new girlfriend and subsequently had another child. Between the ages of seven and eight months, the boys were hospitalized and Eddie's twin brother and mother were diagnosed as HIV-positive. The boys were repeatedly separated from seven to eighteen months due to Eddie's brother's frequent hospitalizations. When the boys were two years old, they were separated from their mother. She asked a friend to care for them during her brief incarceration. While in the care of this friend, who was also a prostitute, the boys were neglected and it is suspected that they observed adults engaging in sexual behavior. The Department of Children's Services intervened placing the boys in temporary foster care and subsequently at the CBA group home.

Even though he was not HIV-positive, the administration and staff of CBA had been willing to provide care for Eddie in an effort to keep the twins together. The boys had resided at the CBA group home for less than three months at the time of the referral to our program. The group home staff had concerns regarding Eddie's sexualized behavior and limited verbal communication skills. They also felt that since the other children in the home were infants and his brother was frequently ill, Eddie would have little opportunity to play or socialize with peers. The administrators from the group home indicated to us that the twins' mother needed to meet court-ordered requirements before she could reunite with her children and that her social worker from the Department of Children's Services had approved our program to meet these requirements.

Eddie's Experience in the Brief Evaluation and Intervention Group

Based on the nature of CBA's concerns about Eddie, our staff considered him an appropriate child for our Brief Evaluation and Intervention Group program. We decided that we could adapt our program to accommodate the complex needs of this child, family, and agency. The initial plan was for Eddie's afternoon caregiver, Penny, to bring him to the two weekly group meetings, one of which his mother would also attend. In consideration of the mother's need to work and difficulty in obtaining transportation, the home visits were scheduled to coincide with her weekly monitored visits.

We initially conceptualized this case with the intent to focus on the mother/child dyad, even though we had anticipated that the mother's participation would be limited. We felt that despite her reduced participation there would be sufficient opportunity for clinical observation and assessment of the mother/child relationship. Although her visits to the boys were irregular, we expected that her motivation to meet the court requirements for reunification would be sufficient to ensure her participation. Our intent was to focus our observations in order to assess Eddie's presumed developmental delays with emphasis on his language acquisition and the quality of his attachment relationships with his mother and surrogate parental figures. Also considering his history, our third area of concern was to evaluate the impact of his suspected exposure to adult sexual behavior.

Upon arrival for the first home visit Eddie was with his morning caregiver, Barbara. His parents were not present. Eddie shyly approached the basket of toys. He took toys and books from the basket over to Barbara and sat on her lap to explore them. Barbara said that many times he had been told that his parents were coming to visit only to be disappointed when they did not show up. However, twenty minutes into this visit the parents arrived. As they entered the room he called out to them and raised his arms in a gesture to be picked up. While his mother did acknowledge him, she and his father were more focused on Eddie's brother who looked weak and sick. Disappointed, Eddie began to suck on his fingers and put toys in his mouth. Mother

reminded Eddie to remove his fingers from his mouth like a "big boy." He refused to sit on his mother's lap when asked. He watched his father hold and play with his brother.

Coming away from this first visit, it was unclear whether the parents would return for the next home visit the following week or whether the mother would come to the group. Our only communication with the mother was through CBA and we had no contact with the father. We had implicitly relied on CBA to encourage if not ensure the mother's participation. After the second week it became clear that Eddie's mother could not get off work to attend BEIG groups. We realized that Eddie's mother's participation was and would continue to be erratic. This unpredictable contact with Eddie's parents meant we had to rethink the focus of our intervention because typically we work with a parent/child dyad. We had to consider whether we could continue working with this case, with the agency staff in the role of surrogate parents.

Our intervention needed to integrate both of Eddie's daytime caregivers into the therapeutic plan. His afternoon caregiver, Penny, came to the group and Barbara, his morning caregiver was involved in the home visits. The number of people involved made it difficult for effective communication and consistent intervention to occur. At times it was even difficult to ascertain with whom we should consult regarding certain issues. One of the most salient challenges for us stemmed from the fact that while we worked directly with caregivers, the authority to make decisions regarding Eddie rested with the administrator of the group home. We redefined the inter-agency collaboration because the agency was no longer the mediator between us and Eddie's parents, they were in effect "the client."

During the first week of the BEIG program Eddie attended the groups with Penny as planned. However his mother did not attend. Initially Eddie was shy and somewhat passive but quite alert and interested in the other children's activities. He appeared to us a sturdy-looking, sweet-natured little boy who looked younger than his two and a half years. Eddie called all female caregivers as well as our female staff members "mama." Eddie came with Penny to the BEIG groups twice a week. She was

an attractive, young woman with a lot of natural warmth who was generally responsive to Eddie. At times in the group we noticed that Penny became so absorbed in exploring the play materials herself that she was unavailable to pick up on Eddie's subtle cues. He was very aware of Penny's whereabouts and wanted to sit near her in the classroom. Yet during outside time, despite her accessibility, he did not check-in or seek comfort from her unless encouraged to do so. In the group he was compliant but his caregivers reported that at home he was negativistic and oppositional.

Of the three children who began the group, Eddie was the youngest. The other two children were a year older and both came with their mothers to the group. A fourth child and his mother joined the group during the third week. Two of the children had precocious language skills. In contrast, Eddie's communication was limited to brief phrases, gestures and pointing. His receptive language was good and he was able to comprehend both his caregiver's and our staff's comments. Eddie started each group session with the play dough. This comforting and structuring ritual allowed him to first observe and then gradually enter into social interactions with his peers. He rarely asked directly for things but played with whatever was set in front of him. Yet he was very responsive to the overtures of other children and staff. With his toddler gait and limited speech, he looked cautiously at the larger, more aggressive children. Initially he was intimidated by one girl's aggressiveness. However, by the end of the second week he sat next to her at the play dough table and offered her a spoon. He soon began to follow her around and imitate her play.

Weekly home visits to CBA continued with Eddie and his morning caregiver, Barbara. She was a young woman of perhaps twenty who although cooperative, seemed uncomfortable with her unanticipated involvement in this clinical intervention. Barbara had little tolerance for Eddie's negativistic behavior. Her expectations of Eddie were somewhat higher than Penny's. She was reserved and seemed more interested in problem solving rather than working through the feelings involved in Eddie's emotional struggles. She frequently left the room during home visits to tend to the other children making it difficult to focus on her interaction with Eddie.

Formulation of Treatment Goals

Our observations of Eddie in the group and at home, led us to formulate treatment goals that would incorporate CBA's concerns as well as Eddie's developmental and psychological needs. One of our main considerations was how to work effectively with multiple caregivers who had different levels of knowledge about developmental issues and varying degrees of tolerance for Eddie's negativistic behavior. It appeared that Eddie's two primary caregivers' alternated between over and underestimating his capacities. Penny was quick to respond if he approached her for help while Barbara had higher expectations of him. They were both caring young women who were invested in Eddie's development. However, Eddie's robust health presented them with different care giving challenges than did the four young infants and Eddie's twin brother who were seriously ill. It must have created a profound emotional dilemma for them to nurture a healthy child in the midst of terminally ill children. This in turn probably made it more difficult to form an intensive attachment relationship with Eddie.

With this in mind, our main treatment goal was to help Eddie's caregivers appreciate his need for a significant attachment relationship with them. To pursue this goal, we emphasized to the administration of CBA that the developmental concerns they had about Eddie needed to be addressed within the context of his relationships with his caregivers at the group home. Some of the specific areas of intervention we focused on were helping Eddie's caregivers to actively prepare him for change, facilitate his transitions and acknowledge his emotional experiences. As his primary caregivers became more able to help him anticipate and integrate his daily experiences, Eddie became more aware of the routines at his group home and thus transitions became more manageable for them.

Over the course of the BEIG program, Eddie learned the names of the other children in the group as well as his teachers' names. He connected with the other kids and would say "hi guys" on the yard and try to imitate their play. His play evolved from passive watching of the other children to engaging in play with a sustained theme. By

the end of the ten weeks, he was able to engage in symbolic play at the water table; he stirred a plastic egg in a pan of water with his finger and then put it on a spoon to "taste."

During the program Eddie also increased his connection with Penny. He would bring toys to show her and checked in with her regularly during the group meetings. He began to show increasing autonomy, became an expert with the routine of the group and responded well to predictability. He was also able to actively ask for help and accept it. We also saw improvement in Eddie during the home visits. As a result of his ability to call caregivers by name and his growing investment in verbally sharing his experience, Barbara reported that Eddie followed her around demanding attention by repeating her name. This irritated her and made it difficult for her to attend to the other children. She noted that Eddie had learned which of his caregivers he could say "no" to and which ones he couldn't and that she was the one who set limits for him. Barbara was able to acknowledge Eddie's need for clarification of the events in his life. She said she was less "blown away" by his tantrums and that they occurred less frequently. Eddie had become more verbal which seemed to make it easier for her to be involved with him in an interactive rather than directive manner. We were pleased with Eddie's progress and the growing tolerance of his caregivers for his developmentally appropriate emotional struggles.

At the agency's request an in-service presentation was made to the entire group home staff. This presentation focused on developmental needs of toddlers and specifically dealt with the struggles and dilemmas faced by Eddie's caregivers with regard to his unique circumstances.

Inter-Agency Collaboration

Most agencies have clients whose needs exceed the limits of services the agency provides. In a recent article, Thomas (1990) points out that the positive aspect of collaboration is that it is often a welcome solution to the burden of one agency taking sole responsibility for a situation when they may not have the resources to meet all the clients' needs. Yet, in order to sustain a system of care and modify it when

necessary, much time must be devoted to "taking the pulse" of participation. Clarification of roles and expectations, specification of obstacles, and communication are necessary components of a successful collaboration.

CBA had shared our disappointment that Eddie's parents were unable to utilize the program as we had hoped they would, yet CBA remained highly invested in continued participation. Not only did they want an assessment of Eddie's difficulties, they felt that our program would prepare him for nursery school and that their staff would benefit as well. Although reunification with the mother was CBA's stated goal, it appeared that this goal was not going to be achieved in the near future. While not directly addressed, Eddie's brother's medically fragile state and his mother's vulnerability to developing AIDS were unspoken yet poignant concerns that must have been somewhere in everyone's thoughts. We speculated that CBA might have been considering viable long-term options for Eddie including the possibility of adoption.

At a follow-up meeting with the social worker and director from CBA we requested their feedback. They felt their agency benefited from their participation in the BEIG program. Specifically they said Eddie was now prepared to enter nursery school, that their staff was more knowledgeable regarding child development issues and more interested in integrating this knowledge into their work with all the children at CBA. The disappointments they expressed were largely due to the limitations of a short-term program. They would have liked the group and didactic training to continue. They also expressed a wish for more specific techniques to handle problematic behavior and more specific feedback from the psychiatric consultation.

We assumed that because the administrators had requested our services that the caregivers had been informed about what we could offer and wanted our input. Although there was little we could do with regard to the unpredictability of Eddie's parental involvement, we felt that we could address the issue of disparity in care giving style among caregivers as well as emphasize his need for consistency. Penny had access to the group and came to our facility twice a week. Her feelings about

being in the group and not being Eddie's mother were discussed. Barbara, on the other hand, did not have the benefit of participation in the groups. Her feelings about her role with Eddie were not processed at the same level as Penny's were. The group and home visit components of our program are both vital to an integrated assessment and intervention. With one caregiver participating in the groups and the other in the home visits, it was difficult to coordinate the interventions we felt would be most beneficial for Eddie. The limited direct communication between these caregivers exacerbated this situation. However, we felt our intervention was successful in that Eddie's caregivers were more able to narrate and clarify his experience by the end of the program. Perhaps we overlooked the need to make explicit what our clinical program could offer them and their role in this collaboration.

Our final assessment of Eddie was that he was a capable child who despite his language delay was communicative and able to form strong attachments. He was able to accept comfort from his caregivers and he responded well to structure, routine and narration of his experience. He showed initiative in using play materials and displayed age appropriate social skills. We saw Eddie as a child who was struggling with age appropriate developmental tasks associated with separation, individuation, and autonomy. The sexualized behavior that CBA reported was not evident during the BEIG program. We felt Eddie would benefit from an opportunity for continued socialization within a normal peer group and a referral for individual therapy did not seem necessary at the time.

At the follow up meeting, the social worker at CBA described Eddie as a more assertive child who conveys a clearer sense of himself as a result of their participation in the BEIG program. Eddie currently attends a local preschool twice a week and an after school program one afternoon a week. He still uses single words to communicate rather than sentences, the agency has obtained a speech therapist for him. The social worker also reported that Barbara no longer works at the agency and described Eddie's reaction to her departure as one of anger and great sadness. However, she did come to visit whereupon he ran and hid. When she approached him they both hugged and

sobbed, showing his capacity for clear and direct emotional reaction to separation and loss.

According to the social worker, the twins' father still comes to visit but is not very involved with them. Their mother still visits irregularly and talks about reunification. She has not yet attended a parenting class but seems more open to obtaining help now than before. Eddie did have a recent overnight visit with her. When she referred to "their" home Eddie replied, "this is mommy's home" making a clear delineation between his home at CBA and hers. Eddie's brother's condition has improved to the extent that he is now able to attend a special education nursery school program five days a week. It is unclear as to what the future holds for Eddie, however, the staff at CBA is still hopeful that the mother will be able to meet the court-ordered requirements in order to reunite with her twins.

Retrospective Analysis

Our role with CBA was similar to our work with parents and their children in that in a ten week evaluation and intervention program one of the challenges is to achieve relatively quickly a collaborative focus on some aspects of a child's experience. Clearly children's difficulties are imbedded in multiple family relationships and contextual issues (such as a family's economic and social situation). Sometimes the staff members working with a family may feel overwhelmed by a sense of chaos about the multiple concerns, needs, and distress that present themselves. The challenge is to sufficiently engage and contain parents multiple needs and feelings (such as distress about their marital relationship) while being aware that we are limiting our therapeutic focus to those relationships or developmental issues which are amenable to intervention within a ten week program. While we clearly must remain open to hear about and acknowledge multiple concerns and help parents find ways of getting the appropriate help, we also attempt to engage them in exploring salient clinical themes regarding their relationship with their young child. So it is a matter of focusing together with parents, or in this case Eddie's caregivers, in observing and thinking about a child's experience. This in itself has a therapeutic effect. A child is usually

aware of adults talking together and problem solving, of their slowing down and attempting to understand what is needed, and their desire for a calmer more satisfying and pleasurable relationship.

In working with CBA on behalf of Eddie we needed to be aware of a systems perspective, realizing that there are multiple concerns, expectations, wishes, and fantasies; some are expressed while others remain silent and still others lie outside of awareness. When we work with a child's parents we have an essential ongoing opportunity to make some of these explicit, to correct their misconceptions and to continually fine tune clinical formulations and interventions as we go along. Perhaps we may have denied the differences between working clinically with a residential care setting and working with a parent/child dyad or family. In working with the caregivers and administrators at CBA there was more focus on developmental guidance and less opportunity for this fine tuning and correcting process that usually occurs with parents. We probably did not fully realize that we proceeded *as if* we were working with a family and we may have missed opportunities to address, explore and make explicit CBA's assumptions as well as our own assumptions.

Upon completion of the BEIG program, it became apparent that the group home social worker had expectations that our program would provide a developmental/psychological evaluation, a socializing pre-nursery experience for Eddie, as well as training experience for his caregivers. Their disappointment emerged only at the follow up meeting and not as we went along. This precluded the exploration or resolution that could have become a part of the working relationship. On our side, an unexamined assumption was that we could work with caregivers as surrogate parents without altering our approach, focusing on how the relationships with the child are functioning in ways that are affectively responsive to a child, that support a child's ability to integrate experience, affirms the child's experience of self, and their ability to negotiate areas of autonomy, to communicate and so on. However, Eddie's caregivers were not parents in a compromised attachment relationship. They had been caring for Eddie for only 3 months in a group home that was not designed to

meet the developmental needs of a healthy toddler. Despite this they struggled to be aware of what he needed from them.

Another important aspect of this case is this child's complex situation, including separation from both parents and living in group care for terminally ill children with his very fragile twin brother. These circumstances are very poignant and dramatic and potentially stir up adults feelings and fantasies. For example, our staff had to struggle with the tendency to over dramatize aspects of this case and another parent became caught up in Eddie's situation, almost becoming so involved that she was avoiding exploring her relationship with her own son. The clinical challenge was not to lose focus of Eddie's strengths. Although initially subdued and delayed in expressive language, Eddie was not deeply withdrawn or depressed. He had not "tuned out," he was highly responsive to affective engagement and reciprocal interaction both with adults and with other children. The challenge here was to focus on the everyday almost mundane developmental needs of a toddler. Developmental guidance was the method and the emphasis was on health rather than pathology and dysfunction. For example, Eddie's need to assert himself with his caregivers, to demand their attention, and to protest when their attention was turned away. This approach is supported by the framework offered in the book Relationship Disorders in Early Childhood edited by Sameroff & Emde. They suggest looking at a child's difficulties not in terms of a diagnosis of a child or of a parent, but instead considering the problem to lie within the relationship. Also in this book, Anders offers the concept of a hierarchy of perturbations, disorders, and disturbances. Using this framework, Eddie's problems lie in the middle as a disorder which is a risk situation. Timely intervention in the relationship attempts to prevent a deeper disturbance from developing within the child.

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